VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

November 4, 2015

Gail Kaminski Potter, Manager
Our Lady Of Providence
47 West Spring Street
Winooski, VT 05404-1397

Dear Ms. Kaminski-Potter:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 5, 2015.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PRINTED: 10/26/2015
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0198	A. BUILDING: _____ B. WING _____	C 10/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF PROVIDENCE	47 WEST SPRING STREET WINOOSKI, VT 05404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site survey was conducted on 10/5/15 by the Division of Licensing and Protection to investigate a complaint regarding resident care services. The following regulatory violations resulted from the investigation.	R100	Our Lady of Providence submits this Plan of Correction under procedures established under the Vermont Residential Care Home Regulations. This Plan of Correction should not be construed as either a waiver of Our Lady of Providence's right to appeal or an admission of past or ongoing violations of regulatory requirements.	
R126 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the home failed to assure that each resident received necessary care to meet their psychosocial, nursing and medical care needs for 1 of 4 residents in the total sample. (Resident #4) Finding include: Per record review on 10/5/15, Resident #4 experienced frequent falls, and on multiple occasions was able to successfully elude staff and leave the second floor unit and proceed unattended to the first floor, where s/he was found distressed and/or on the floor on the following dates from 3/18/15 - 5/1/15. 1. On 3/19/15, the resident was found hanging on the lockers in back hallway and then attempted to leave via the exit door.	R126	R126 Resident #4 expired on 7/2/2015. An audible wander system was installed on 9/23/2015, and staff have been in-serviced. Residents at risk for wandering can now be provided with a wander bracelet, alerting staff when they are near an unsafe area. Resident #4 was moved to the first available room on our first floor on 5/1/2015. One on one supervision was provided on numerous occasions, and diversional activities supplied. All interventions, including eyes on supervision, monitoring of the resident's physical location, and the provision of physical assistance will be included in resident care plans. Staff will be in-serviced on including such interventions on the Plan of Care. All Care Plans will be audited by a designated RN for	

R126-R213 POCs accepted 11/2/15 PMcotarn

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R126	Continued From page 1 2. On 3/21/15, the resident was found in the 1st floor Emilio hall without a walker, unassisted, 'had gone down the back stairwell without assist of any kind...staff told to check frequently'. 3. On 3/27/15, at '10:30 PM,' the resident 'was restless....found half way down the back stairs and needed to be helped back to room'. 4. On 4/19/15, the resident was "found lying on 1st floor outside the trash room door...unwitnessed fall, transferred via gait belt and 2 assist in wheel chair' The nursing note continued' "requires supervision at all times, esp. during meal times". In addition to these events, the resident also sustained falls in their room. Nursing staff failed to assure that the resident received adequate supervision by staff to assure the resident's safety at all times. Per review, the care plan failed to provide specific direction to staff to include monitoring the resident's whereabouts and provision of physical assistance as needed. The resident was able to leave the second floor unit unattended multiple times by ambulating unsafely down the stairs near h/her room, near the end of the corridor and farthest away from the nurses' station. Despite these incidents, staff were not directed to provide consistent eyes on supervision to prevent these unsafe actions that posed a risk of serious harm to this resident. During interview on 10/5/15 at 3:05 PM, the ADM stated that "In hindsight, they may have tried some other things to better monitor...i.e., door alarms."	R126	completeness. In addition, the DON/NHA will review the 24 hour reports daily, and cross reference the care plans for any appropriate changes which should be included. The DON and Administrator will also audit the Care Plans on a quarterly basis to ensure they are complete and provide specific direction to staff. Goal Date: 11/30/2015 R151 All Behaviors and behavioral interventions will be documented on behavioral flow sheets and in the nurses' notes. This shall include any changes in a resident condition which necessitate the use of anti-psychotic medication. An in-service, Psychotropic Drug Use: Legal and Ethical Issues, presented by our Consultant Pharmacist was conducted on 10/22/2015. The DON and Consultant Pharmacist shall monitor the above process on a quarterly basis. Goal Date: 11/30/2015 R 213 Since Resident #4 was found on the floor, this incident was treated as a fall by the staff. Attempts were made to assess the resident and obtain neuro-vital signs. On	
R151 SS=D	V. RESIDENT CARE AND HOME SERVICES	R151		

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R151	Continued From page 2 5.9.c (8) Ensure that the resident's record documents any changes in a resident's condition; This REQUIREMENT is not met as evidenced by: Based on staff interview an record review, the facility failed to assure that each resident's record documents any changes in a resident's condition, related to symptoms that were so severe that anti-psychotic medication was administered to a resident by staff of the home. (Resident #4) Findings include: Per record review on 10/5/15, Resident #4 experienced an unwitnessed fall on 4/19/15 with no injuries noted, and without any evidence of a clear indication for use, the nurse on duty administered a PRN (as needed) dose of Haldol, an antipsychotic medication ordered specifically for agitation. The resident was noted to be missing from their second floor room at 1800 (6 PM). After a search the resident was found lying on the floor on the first floor level, near the trash room. The resident had recently experienced multiple falls due to poor safety awareness, resulting in unsafe actions including attempts to ambulate without supervision and staff assistance. After the fall, per the nurse's progress note of 4/19/15 at 1820 HR, the resident was 'back in [his/her] room, had PRN Haldol 1 mg., had positive effect....[s/he] rested in the room for the rest of the evening'. The physician orders for the Haldol stated "1 mg. PO (by mouth) Q 6 HR as needed for agitation". There was no documentation in the nursing notes of any	R151	7/7/2015, after the date of the incident, but before the survey, an in-service was held. Topics covered included the right to refuse treatment and medication. Staff involved in the above incident were present at this in-service, and a copy was provided to the surveyor. In fact, when the resident declined her medications earlier that morning, the nurse left. After any incident, we will attempt to assess the resident, and obtain vital signs, as appropriate. We will leave and re-approach if the resident becomes combative, as long as the resident is deemed safe. We will conduct an additional in-service on Behavior Management with Challenging Residents. This process will be monitored on an on-going basis by the NHA and DON. Goal Date: 11/30/2015	

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R151	Continued From page 3 resident behaviors or agitation pertaining to that time period. Per review of the behavior sheets for 4/19/15, the documentation did not identify any non-pharmacological (non-medication) interventions that were attempted prior to giving the antipsychotic medication, it only stated to see the nursing note, which contained no evidence of any behaviors that would warrant the use of a strong antipsychotic medication. The medication had the effect of chemically restraining the resident and keeping him/her in their room for the evening. The improper administration of the antipsychotic medication Haldol, given without sufficient evidence of agitation, was confirmed during interview with the Administrator and the DNS (Director of Nurses) at 4:45 PM.	R151		
R213 SS=D	VI. RESIDENTS' RIGHTS 6.1 Every resident shall be treated with consideration, respect and full recognition of the resident's dignity, individuality, and privacy. A home may not ask a resident to waive the resident's rights. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to assure that all resident's were treated with respect and in full recognition of their right to dignity for 1 applicable resident in the survey. (Resident #4). Findings include: Per record review on 10/5/15, Resident #4 was experiencing a mental and physical decline and staff failed to provide nursing care that was	R213		

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R213	Continued From page 4 respectful and appropriate for their physical and psychosocial needs on 4/24/15. The resident had refused the morning medication at 5:30 AM, per the nurse's progress note. At 5:35 AM, the notes document that the resident was sitting in their closet in their private room, "resting their head on a bag of briefs. The resident was very resistant to staff help, assist X 3 to get res. to chair as [s/he] was kicking, hitting...staff [indicating the staff's actions to move the resident were against the resident's will]." The nurse persisted in attempts to get neuro-vital signs and administer the morning medications instead of honoring the resident's refusals, likely further agitating the resident after their initial refusal to take the medications. The resident was not at any risk of harm by resting in the closet. During interviews with the ADM and the DNS, they confirmed the best action was to re-approach as needed but not to force the resident at the time of the refusal of care.	R213		